

Offering Welcome in the Kingdom of the Sick: A Physician Guide to Hospitality

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Abstract

The onset of acute illness may be accompanied by a profound sense of disorientation for patients. Addressing this vulnerability is a key part of a physician’s purview, yet well-intended efforts to do so may be impeded by myriad competing tasks in clinical practice. Resolving this dilemma goes beyond appealing to altruism, as its limitless demands may lead to physician burnout, disillusionment, and a narrowed focus on the biomedical aspects of care in the interest of self-preservation. The authors propose an ethic of hospitality that may better guide physicians in attending to the comprehensive needs of patients that have entered “the kingdom of the sick”. Using philosophical methods, the authors explore what compels people to present to emergent medical attention and why altruism may not offer physicians a sustainable way to address the vulnerabilities that occur in such situations. They then present the concept of hospitality from a Derridean perspective and use it to interpret a narrative case of an on-call paediatrician caring for an infant with bronchiolitis to demonstrate how this approach may be practically implemented in the acute care hospital context. Hospitality allows physicians to acknowledge that clinical presentations that are routine in their world may be disorienting and frightening to patients experiencing them acutely. Further, it recognizes that the vulnerability that accompanies acute illness may be compounded by the unfamiliarity of the hospital environment in which patients have sought support. While it is unlikely that anything physicians do will make the hospital a place where patients and caregivers will desire to be, hospitality may focus their efforts upon making it less unwelcoming. Specifically, it offers an orientation that supports patients in navigating the disorienting and unfamiliar terrains of acute illness, the hospital setting in which help is sought, and engagement with the health care system writ large.

Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.¹

Introduction: Illness and hospital as unfamiliar territory

Sontag’s characterization of the illness experience as an entry into the “kingdom of the sick” aptly captures the displacement that people may experience when they, or their loved ones, become patients. Both the illness itself and the unfamiliarity of what is happening with one’s own or a loved one’s body, and the new territories associated with the illness—physicians’ offices, waiting rooms, hospital wards, et cetera—can lead to a profound disorientation and need for guidance. Just as when one enters a new geographic territory and encounters new languages, customs, people, spaces, sounds, and smells, the kingdom of the sick comes with its own language, customs, people, spaces, sounds, and smells.

This disorientation has been recognized in the medical humanities. Frank opens his book with these words of a patient with a chronic illness: “The destination and map I had used to navigate before were no longer

useful.”² Biro similarly describes the alienation and estrangement that patients experience from their bodies and the rest of the world. With reference to Sontag’s geographical metaphor, he writes: “Entering the land of the ill, personally or vicariously (caring for loved ones or listening to and reading the stories of patients), we quickly realize how consuming the experience is.”³

Attending to all aspects of the experience of illness, including this disorientation, are part of a physician’s professional purview. The needs of patients newly arrived in the “kingdom of the sick” are often myriad, however, and may place significant requests upon physicians already busy with the demands of clinical practice. In part to ensure that physicians account for these needs, professional organizations have invoked the core value of altruism, “the capacity to put the needs and interests of another before your own.”⁴ Yet reconciling altruism, a concept that is not only “intangible and opaque”⁵ but also limitless, with the realities of contemporary healthcare may lead to “burnout, work–life imbalance and overall career dissatisfaction.”⁶ As such, governing and accrediting bodies^{7,8,9} have put some limits on altruism by recognizing, to varying degree, the need for physicians to also care for themselves. In the interest of self-preservation, some physicians may simply not acknowledge the disorientation and alienation that accompany illness, or consider them beyond their biomedical responsibility.

How might we re-interpret the laudable value of altruism in such a way that it supports physicians in charting a course away from the dangers of over-commitment and burnout, while also recognizing the core need for patient guidance and support in the unfamiliar terrain of the “kingdom of the sick”? We might examine this issue in more depth through exploring one part of this kingdom with which many physicians are intimately familiar: the acute care hospital environment.

It is easy to forget that the hospital’s landscapes and the movements, sounds, and medical discourse that flow through them – so natural to physicians after years of training and practice such that the hospital has become a second home to them – is often jarringly unfamiliar and unhomelike¹⁰ for patients and their families. As one way, then, to attend to the lofty desires of altruism yet ground them in the complex realities of providing health care, this paper proposes *hospitality* as an ethical framework that is particularly well-tailored to the hospital context in which a significant proportion of medical education and health care continue to unfold. Hospitality, in the way in we will discuss it – namely based on the work of the French philosopher Jacques Derrida – is altruistic in the sense that it is other-centred, but it also takes into account the context in which some people come to function as hosts, whereas others find themselves in the position of guests, visitors, or strangers. Moreover, an ethic of hospitality pushes back against more behaviouristic and assessment-driven conceptions of altruism,⁵ clearly insisting that it is an ethic that cannot be perfected and evading the “moral calculus” and certainty of knowing one has done the right thing.

The paper will first explore the hospital as a place in which people seek relief from the unhomelike state of illness. It will outline a Derridean ethic of hospitality, exploring it in the context of other literature on altruism, while arguing for its ability to provide a sharper focus upon medical practice and education than the concept of altruism currently does. It will then present and analyze the (composite) case of parents bringing their four-month-old infant with breathing difficulties to medical attention in order to demonstrate how this ethical framework situates an individual health care provider into a specific type of response to the demands of patient care. Finally, it will offer some considerations for how an ethic of hospitality might be optimally integrated into medical education curricula.

Methods

This paper does not present the results of an empirical study. Rather, it proceeds by way of philosophical argument, focusing on the central moral concepts guiding medical practice and medical education in attending to patients’ and their families’ illness experiences. After a brief discussion of the concepts of altruism and empathy, including how these have been treated variously as feelings, virtues, and assessable behaviours, the paper explores hospitality as a broad orientation or ethos.

The paper includes what could be called a philosophical case study. As Worthham observes, “philosophers often use hypothetical examples, or decontextualized versions of real examples.”¹¹ In the present context,

a decontextualized, hypothetical example might say: “For example, if a physician is confronted with a sick child’s distraught parents, how can this physician be attentive to the full scope of the parents’ distress?” Such a schematic example can be useful as a quick reminder to the reader of the type of situation in which parental distress manifests itself, or the type of situation in which attentiveness may be challenging. However, Wortham quite rightly points out that “examining a fuller empirical description of a real case can confront philosophers with dimensions that they had not considered.”¹¹ In this paper, the thicker description of the context of the case, including the time of day, the age of the child, the physician’s state of mind, the physical aspects of the hospital, and so forth, provide greater insight into the various sources of disorientation and displacement that call out for a hospitable response. While the case is a composite in the sense that the details have been taken from several real-life situations, it is representative of a clinical scenario that regularly occurs.

Context: Illness as unhomelike

We start by asking a seemingly straightforward question: what might compel someone to come to the doors of an emergency room in the middle of the night, asking for help? Building upon Weber’s premise that civilizations organize themselves around certain understandings of the nature of suffering and the means by which suffering can be transcended and salvation achieved,¹² Good suggests that medicine has come to occupy this role in contemporary Western societies. Specifically, he notes that “the maintenance of human life and the reduction of physical suffering have become paramount”; modern health care practices are powerful agents of deliverance from the anxieties of sickness, finitude, and death.¹³

To further understand the vulnerabilities that accompany the arrival of a patient in the ER in the middle of the night, we need to consider that most people manage disturbances to their usual baseline of health and well-being without seeking the support of professionalized medicine.¹⁴ Even if clinical attention is required, it is only a small minority of health care interactions that occur in the acute care setting.^{15,16} By the time someone has presented to clinical attention in the middle of the night, usual attempts to address illness have likely been insufficient. We might say that illness has unmoored a person from the intimate familiarities of everyday life, putting them into a state not just unfamiliar but distinctly “unhomelike” in both one’s self and the world.^{17,18} The anxiety that accompanies this loss of home is existential: to give but one example, we might consider parents watching their previously well baby who had just a runny nose a few hours prior struggle to breathe. Being unsure as to why and feeling powerless to help the person they arguably know better than anyone else is terrifying.

The acute care hospital, previously described as “the stage on which the miracle play of modern medicine reaches its climax”,¹⁹ is a key location in which medicine offers the promise of delivery on societal expectations of deliverance. Admittedly, the acute care hospital’s position as the central hub around which medical education and practice turns is receding. Among these reasons include a decreasing number of acute care beds, shorter average length of stay, and an ability to manage conditions in an outpatient setting that used to require in-patient resources.^{20,21} Yet in the current design of the Canadian health care system, there really is not anywhere else to go at 2:00 AM, leading us to ask how those waiting on the other side of those doors are to act when someone arrives.

Altruism and its challenges in medical education

Altruism offers one possible way by which medical professionals may attend to this arrival and the myriad needs and vulnerabilities that accompany someone arriving at an inhospitable time of night. It has been described as “the cornerstone of the Hippocratic oath and other professional codes of conduct”,⁵ underlying organizational charters,²² doctrines of humanistic healthcare,⁴ and influential competency-based medical education frameworks.^{8,9} Altruism has a long history in Western thought,^{23,24} yet as a concept in medical education and practice it “remains “intangible and opaque” to scholars⁵ and medical students²⁵ alike.

Various scholars have attempted to address this lack of conceptual clarity around the teaching, learning, and practice of altruism. Altruism has been defined both as the selfless intention informing a person’s actions, or the observable actions themselves. For example, Myers defines it as “a *motive* to increase another’s

welfare without conscious regard for one's self interests,"²⁶ while McGaghie et al 2002 call for behaviour-based models that can be aligned with standardized measurement tools.⁵ With the goal of better balancing the needs of others and the needs of physicians in the contexts of 21st century practice, Burke and Kobus 2012 suggest altruism give way to the development of "empathy and pro-social behaviours" in individuals and an "integration of humanistic curricula into medical education".⁶ In light of its emphasis on "utter self sacrifice", others have cast altruism aside entirely in favour of virtue ethics and the cultivation of *phronesis*.²³

We also see traces of altruism in biomedical ethics familiar to those in active medical practice. The principle of beneficence suggests that physicians act with the intent of not just doing the bare minimum for patients, but providing high quality care with respect to empathy, kindness, and maximizing utility insofar as this value does not come into conflict with non-maleficence, justice, and autonomy.²⁷ However, the principlist framework – while exceptionally useful as a practical tool for adjudicating competing claims, desires, and interests in the provision of healthcare – is less equipped to account for an overall orientation to medical care and practice. Taken together, altruism remains a fraught concept for an individual physician to put meaningfully into practice. On the one hand, it has been reduced to something that can be reliably measured through behaviour, while on the other hand, it remains an ethos of practice and orientation to the needs of others that is expansive yet lacks direction.

Hospitality

Derrida discusses hospitality in a way that is both connected to, and distinct from, more familiar understandings of the concept. As in more everyday ideas and practices of hospitality, Derrida's understanding of hospitality is about receiving people, or creating the conditions for their reception, whether they are invited guests or unfamiliar strangers. However, where everyday ideas and practices of hospitality are concerned with the kinds of things a host can and should do in order to satisfy the cultural codes and moral demands of hospitality, Derrida presents it as a necessary response that cannot be perfected and will always fall short. "The other may come, or he may not. I don't want to programme him, but rather to leave a space for him to come if he comes. It is the ethic of hospitality."²⁸ Offering a hospitable welcome means that one should prepare for the other's arrival, but with the understanding that this other may never arrive, or not at the time they were expected or the host was best prepared, or with needs that are not aligned with the host's preparations.

Hospitality is altruistic in the sense that it is other-directed and it puts the needs of the other first. In fact, Derrida goes a step further and positions the host as dependent on the guest or stranger: "... the welcoming one is welcomed. He is first welcomed by the face of the other whom he means to welcome."²⁹ Without a guest or stranger to receive, one cannot be a host; without patients, one cannot be a physician. Hospitality has similarities with beneficence but is much less confident about its ability to get it right. The person in the position of host must make an effort to ascertain the needs and interests of the other, but may discover that even a well-intentioned gesture of hospitality does not actually enable the other to find a place.

What a Derridean concept of hospitality allows us to see more sharply for medical practice and education than other ethical concepts and frameworks is that the place where a patient is received is not mere background, but is an integral part of the experience of the experience of receiving care. In the experience of patients and their families, medical diagnosis and treatment are not stand-alone interactions; rather, they are parts of a longer or shorter sojourn in the kingdom of the sick, a place with which physicians and other health care providers may be thoroughly familiar, but that for many patients is impersonal, incomprehensible, alienating, and perhaps even threatening.

While hospitality in the everyday sense means typically that one offers hospitality from one's own home, or perhaps a space one has rented for the specific purpose of receiving one's guests, the hospital is a work environment that physicians do not own or control. Is it still appropriate to speak of "hospitality"? Ruitenbergh discusses an ethic of hospitality in education, which involves teachers offering hospitality from classroom and school spaces they do not own or control. She writes that this situation may be more conducive to hospi-

tality because there can be no illusion of ownership or control.³⁰ Derrida cautions that making the gesture of hospitality may confer a sense of ownership on the host that can get in the way of other-centeredness: “To dare to say welcome is perhaps to insinuate that one is at home here, that one knows what it means to be at home, and that at home one receives, invites, or offers hospitality, thus appropriating for oneself a place to *welcome* ... the other...”²⁹ Similar to a teacher’s welcome into an educational space, a physician’s welcome into a medical space must be “a more humble gesture made by a host who knows that she herself has been received and that she is not truly in possession of her home.”³⁰

As discussed earlier, there is an irreconcilable tension between the limitless demands of altruism, and the interests of self-preservation. An ethic of hospitality is similarly limitless but its purpose is not to be fulfilled. Rather, it serves as a corrective aspiration and a reminder that ticking the boxes of codified professional ethics is insufficient for an ethical response to patients and families. Hospitality in this Derridean sense cannot be hospital policy, but a policy that “does not maintain a reference to this principle of unconditional hospitality” is a policy that cannot do justice to its patients.³¹

Offering hospitality in unwelcoming conditions

What might an offer of hospitality look like in the complex and busy landscapes of the hospital? Consider the following scenario: it’s 2:00 AM and I (BS) am on call at the tertiary general hospital I have worked at for a number of years. My shift started about seven hours ago, and I already have been run off my feet by physician colleagues asking for consults, nursing colleagues asking for re-assessments, and an incessant pager laying siege to my best efforts to provide undivided attention to tasks at hand. The pager has gone off yet again, this time from the emergency room (ER) physician, while I am in the process of examining a newborn baby whose delivery I attended for concerns around an abnormal heart rate just before birth.

I quickly finish the exam, leave the labour and delivery unit, and arrive downstairs ten minutes later in the ER to find a four-month-old in significant respiratory distress. She is in her worried mother’s arms, working hard to breathe with indrawing of her chest wall and nasal flaring. She has a series of probes on her body to measure her vitals, which are somewhat tenuously attached as the adhesive is no match for her movements. The large monitor by her bedside tells me that her saturation levels are in the high 80s despite receiving a half-litre per minute of supplemental oxygen, yet the alarms continue to ring without warning as she moves unpredictably and the probes temporarily dislodge from her skin.

Her father is pacing around the room, a circuit from which he is regularly jolted by the monitor’s unpredictable ringing. He maintains a veneer of civility and kindness towards me yet is obviously exhausted. In between the alarms, they tell me that their daughter started with a runny nose, mild cough, and low-grade fever three days ago but seemed otherwise well. As new parents, at the outset of the illness they had spoken with their friends and also contacted public health, all of whom recommended careful observation. They initially had not had many concerns, as she was born on time after an uncomplicated pregnancy and had been growing and developing well to this point. However, as she was not getting better, the parents brought her to a walk-in clinic earlier in the day today. At that point, they were advised to continue to observe her, try acetaminophen for fever as needed and a bulb suction to remove her nasal secretions, and to seek medical attention if she worsened.

Over the last eight hours, their daughter has become much less interested in breastfeeding, only had one wet diaper compared to her usual three over this time period, and has begun breathing much faster. She became much harder to console, had clear tugging at her trachea, and her rib muscles appeared to be moving far more than usual. They tried the bulb suction multiple times and gave two doses of acetaminophen, but nothing seemed to help. Given the late hour, they debated about waiting until the morning to have her assessed but ultimately decided to head in to the hospital.

Once they arrived at the emergency entrance, a nurse met them at triage, asked them a rapid string of questions, and took the baby’s vital signs. The nurse’s brow furrowed when he saw the oxygen monitor reading. He stood up quickly and told the parents to follow him with the baby. He brought them to the room they were currently in, one that had a sliding glass door separating it from the rest of the ER, was

brightly lit with fluorescent lights, and had a single hospital bed and a chair in it. Another nurse appeared five minutes later to ask similar questions and to attach the baby to the monitors. She raised her eyebrows at the oxygen reading and, saying something about pneumonia and that she would be right back, walked out quickly. Fifteen minutes later, another person wearing scrubs who identified herself as the emergency room physician proceeded to ask them a similar set of questions and to examine the baby. She told the parents that she was concerned for the baby's health and thought she had a significant respiratory infection. The parents remember her saying that she thought it was possibly bronchitis or something like that, but she wanted to have the paediatrician consult and advise on next steps before any further decisions were taken.

Not whether to respond, but how

While this scenario of a baby with clinically significant bronchiolitis is fictional, situations like it are very similar to the rooms I (BS) have walked into many times, both in this hospital and others like it, spaces that are, after fifteen years of training and practice, home for me. Like many of my healthcare colleagues in moments like these, I am exhausted, worn down by the fulfilling but emotionally charged work of looking after children and their caregivers when the former are sick and the latter are often afraid, frustrated, and exhausted themselves. Despite that, when on call, there is no choice of *whether* to respond or not. The only choice is *how* to respond to those seeking help at our doors at this late hour, a choice that may be informed by drawing upon an ethic of hospitality.

My ability to offer hospitality in this scenario is contingent upon people seeking it out in the dark hours of the night. When on call, I await the arrival of people who may never come, yet despite the above pressures and demands on time laid out above, I must be at my best if they happen to appear. Even if I create space in anticipation of receiving someone, I cannot know what that space will look like and how it will be enacted *until* the person arrives. I have looked after over a hundred children presenting with bronchiolitis throughout residency and now independent practice, yet what the illness experience looks like for *this* family at *this* time in *this* location will call me into being in a unique way. Further, I might recognize the biomedical condition, but I really have no way of knowing what sort of requests or demands *this* family living *this* illness will make of me. So, space is made and the lights are left on, but the future is totally unwritten, the ambiguity of what could happen inexplicable until a specific person arrives, asking for hospitality.

Given the frequency of clinically significant bronchiolitis in infants, combined with the late hour and the bonecrushing fatigue that accumulates after years of training and practice, I suppose that I could be forgiven for being somewhat disinterested in this specific clinical encounter and for trying to get through things as quickly as possible. As such, diagnosis could solely exist as the means to structure biomedical treatment and fix the problem at hand. My challenge is to remember that health care encounters, while sought out, almost always involve people not really wanting to be there. There are undoubtedly countless other places that caregivers would rather be than in an emergency department with a sick baby in the middle of the night. That they are indeed here indexes a sense of being bereft of options, cast out of the familiarity of their lives, at a loss to name what is happening, and feeling uncertain as to how to help their baby.

Brought to bear on this scenario, then, an ethic of hospitality illustrates three key aspects. One, my presence in health care encounters is not a given; rather, I am called into presence as a paediatrician each time anew by patients asking for help. Certainly, I can draw on the somewhat standardized affordances that a correct diagnosis offers for biomedical aspects of this encounter – among others, oxygen, suctioning, and ensuring appropriate monitoring and nutrition. Yet an ethic of hospitality also invites me into the unique lived experience of *this* clinical encounter, one in which clinically significant bronchiolitis in *this* infant's life is likely to be extremely rare, one in which we attend to the other, less clinical and more existential function of diagnosis: “to symbolize the source of suffering, to find an image around which a narrative can take shape. To name the origin... is to seize power to alleviate it... and is also a critical step in the remaking of the world, in the authoring of an integrated self”.¹³

Second, it compels us to acknowledge the sharp edges of *this* family's double vulnerability – the precarity that comes with the “unhomelikeness” of illness¹⁸ and the strangeness of the acute care centre world in which they

now find themselves. That parents, experts in their child, come seeking answers and support from complete strangers – albeit those in socially legitimated roles like the ones physicians embody – is testament to the ruptures in everyday life that significant illness brings. Adding to this vulnerability is the common perception of the acute care hospital context as both unfamiliar and daunting to caregivers and children, particularly when under the duress that significant illness brings. Movements from triage to exam room to in-patient bed, contact with myriad health care professionals, and the indiscriminate blaring of monitors that may indicate low oxygen saturations but may also simply be reacting to the normal movements of a four-month old all confront people with a massive amount of information, often when they are already exhausted. Further, even “well-educated” caregivers, unlike the health care professionals they may be meeting for the first time, are not typically immersed in a biomedical worldview, fluent in the sociolect of professional medicine, or familiar with the logic of questioning and examination that are part and parcel of clinical encounters.

Third, then, an ethic of hospitality also lays bare that a health care professional’s expertise and experience are ways by which we may “unlock” the unintelligible aspects of this world.³⁰ While it is unlikely that anything I do will make the hospital a place where patients and caregivers will ever desire to be, I can focus my efforts upon making it *less unwelcoming*, acclimatizing them to this novel context and recognizing their need to incorporate this time of unfamiliarity into their broader life narrative.

What is to be done?

While we have a choice *how* to respond on an individual level to a situation like the above, an ethic of hospitality also demands consideration as to why the current design of our health care system may obstruct fuller expressions of hospitality in the first place. We might rightly ask why the design of acute care spaces conjures unfamiliarity in the first place. We might ask to which degree health care systems may carry negative connotations for those accessing them, thinking specifically of the long history of colonialism and structural violence that has impacted Indigenous peoples living in what is now Canada. We might ask how the affordances of the medical language that clinicians employ – so useful in effecting biomedical treatment – may be limited by the impenetrability of that language to many families. We might ask whether a more robust primary health care system may have meant an earlier assessment of this infant, preventing him or her from falling behind on secretion clearance and breastfeeding. These are necessary questions that the demands of busy clinical duties might prevent us from addressing, that current curricular content and design might not adequately position us to even ask, and that a system that demands exhaustive expressions of altruism from its individual practitioners to shore up its shortcomings may obstruct.

It is undeniable that the onset of acute illness is a time of unavoidable precarity. While there may be little we can do to offset this aspect, infusing clinical care with an ethic of hospitality may open up needed space to better understand how professional medicine can provide care that goes beyond only addressing the biomedical aspects of illness. Specifically, it provides us with an orientation and a language that may speak to the silences that shroud patient experience of the unhomelike state of illness and the journey into the kingdom of the sick, the additional disorientations that may accompany a family’s navigation through the landscapes of the acute care setting, and the vulnerabilities and anxieties that accompany patient engagement with health care systems writ large.

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